DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: U T — 0 1 - 010

2. STATE: UTAH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
JANUARY ~~April~~ 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN XX☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.20

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $-0-
b. FFY 2002 $-0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-B, Pages 1, 2, 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 4.19-B, Pages 1, 2

10. SUBJECT OF AMENDMENT:
Outpatient Hospital and Other Services

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Rod Betit

13. TYPED NAME: Rod L. Betit

14. TITLE: Executive Director
Department of Health

15. DATE SUBMITTED: ~~April 5, 2001~~ MARCH 29, 2001

16. RETURN TO:
Rod L. Betit, Executive Director
Department of Health
Box 143102
Salt Lake City, UT 84114-3102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: April 4, 2001

18. DATE APPROVED: 6/11/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: David Selleck

22. TITLE: Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: March 30, 2001

A. OUTPATIENT HOSPITAL AND OTHER SERVICES

1. Except for emergency room, lithotripsy, Federally Qualified Health Centers, laboratory and radiology services, the payment level for outpatient hospital claims will be based on 77% allowed charges for urban hospitals and 93% allowed charges for rural hospitals.

2. Payments for emergency room services vary depending on urban/rural designation and whether the service is designed as "emergency" or "non-emergency." The "emergency" designation is based on the principal diagnosis (ICD-9 Codes). Rural hospitals will receive 98% of charges for emergency services and 65% for non-emergency use of the emergency room. Urban hospitals will receive 98% of charges for emergencies and 40% of charges for non-emergency use of the emergency room.

3. Payment for lithotripsy services is a fixed fee of $2,800. The $2,800 fee is all-inclusive except for physician services that are billed on the HCFA-1500. The rate includes all services related to lithotripsy for 90 days. No additional payment will be made for repeat procedures within the 90-day period. Treatment of the kidney on the opposite side will be paid as a separate treatment, but is also subject to the 90-day restriction. The payment rate will be reviewed and updated annually using economic trends and conditions.

4. Payment for laboratory and radiology services provided in a hospital to outpatients will be made based on HCPCS codes and an established fee schedule, unless a lesser amount is billed. The fee schedule used to pay physicians is used to establish payment rates.

5. Billed charges shall not exceed the usual and customary charge to private pay patients.

6. Payments for all outpatient services are limited to the aggregate annual amount Medicare would pay for the same services as required by 42 CFR 447.321.

7. Payments for physical therapy/occupational therapy are based on the established fee schedule unless a lower amount is billed. Fees are established by discounting historical charge, by professional judgement, and by the physical therapy and occupational therapy fee schedule. Since the amount of physical therapy and occupational therapy is limited, the select case management committee of the facility will determine which type of service (physical therapy or occupational therapy) should be provided for the patient by the facility. The amount of physical therapy provided will affect the amount of occupational therapy available, and vice versa.

A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

FEDERALLY QUALIFIED HEALTH CENTERS

Payment for Federally Qualified Health Center services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

All Federally Qualified Health Centers are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the center's reasonable costs for the center's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the center's fiscal year 2001. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each center fiscal year thereafter, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the center during that fiscal year. The center must supply documentation to justify scope of service adjustments.

For newly qualified FQHCs after State fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers, and adjustments for increases or decreases in the scope of service furnished by the Center during that fiscal year.

In the case of any FQHC which contracts with a Medicaid managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

Until a prospective payment methodology is established, the state will reimburse FQHCs based on the State Plan in effect on December 31, 2000. The state will reconcile payments made under this methodology to the amounts to which the center is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the centers for the interim period.

A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

RURAL HEALTH CLINICS

Payment for Rural Health Clinic services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

All Rural Health Clinics are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the clinic's fiscal year 2001. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each clinic fiscal year thereafter, each clinic will be paid the amount (on a per visit basis) equal to the amount paid in the previous clinic fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that fiscal year. The clinic must supply documentation to justify scope of service adjustments.

For newly qualified RHCs after State fiscal year 2000, initial payments are established either by reference to payments to other clinics in the same or adjacent areas with similar caseload, or in the absence of other clinics, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics, and adjustments for increases or decreases in the scope of service furnished by the clinic during that fiscal year.

In the case of any RHC which contracts with a Medicaid managed care organization, supplemental payments will be made quarterly to the clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the clinic is entitled under the prospective payment system.

Until a prospective payment methodology is established, the state will reimburse RHCs based on the State Plan in effect on December 31, 2000. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.